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GOVERNMENT EMPLOYEES HEALTH BENEFITS PROGRAM

AUGUST 20, 1959.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. MURRAY, from the Committee on Post Office and Civil Service, submitted the following

REPORT

[To accompany S. 2162]

The Committee on Post Office and Civil Service, to whom was referred the bill (S. 2162) to provide a health benefits program for Government employees, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

AMENDMENT

The amendment proposed by the committee to S. 2162 strikes out all after the enacting clause and inserts in lieu thereof a substitute text which appears in italic type in S. 2162, as reported by the committee of the House. A discussion of the effect of this proposed amendment is contained in the explanation of the bill, as reported.

STATEMENT

PURPOSE

The general purpose of this legislation is to facilitate and strengthen the administration of the activities of the Government generally and to improve personnel administration in the Government by providing a measure of protection for civilian Government employees against the high, unbudgetable, and, therefore, financially burdensome costs of medical services through a comprehensive Government-wide program of insurance for Federal employees and their dependents, the costs of which will be shared by the Government, as employer, and its employees.

At the present time, a wide gap exists between the Government, in its capacity of employer, and employers in private enterprise, with

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respect to health benefits for employees. Enlightened, progressive private enterprise almost universally has been establishing and operating contributory health benefit programs for its employees. Until now, the Government has made scant progress in this area.

This bill is designed to close the gap which now exists and bring the Government abreast of most private employers. It will enable Government employees to purchase protection, at a cost which is within their means, from the unanticipated and usually oppressive costs of medical care and treatment in the event of sickness or injury, as well as the often crushing expense of so-called catastrophic illness or serious injury. Availability of this health protection program to Government employees will be of material assistance in improving the competitive position of the Government with respect to private enterprise in the recruitment and retention of competent civilian personnel so urgently needed to assist in maintaining and improving our strong national defense and in the operation of other essential Government programs.

The addition of the health insurance program provided by the bill to the existing fringe benefits package for Government employees—which currently includes retirement and survivor annuities, group life insurance, annual and sick leave, compensation for job-connected injury or death, and other benefits—will fill a long, keenly felt need and will place the Government on a substantially equal level with progressive industry in respect to employee fringe benefits.

Legislation to establish a health benefits program for Federal employees has been before the Post Office and Civil Service Committee in each Congress beginning with the 83d. Hearings were held in 1956 on an administration proposal to provide Federal employees protection against the bankrupting expenses of extended castastrophic illness of injury, with the Government sharing the cost. The reported bill incorporates the outstanding feature of that plan—"major medical" protection against the expense of castastrophic illness or injury—and, in addition, provides protection for basic health needs. Thus the bill affords Federal employees an opportunity to obtain comprehensive insurance for health services at moderate cost.

The urgent need for a joint Government-employee health benefits program is emphasized by the fact that there is widespread and increasing recognition on the part of the public that both basic health and major medical insurance coverages are essential to protect wage-earners and their families. In 1940, approximately 4 million individuals were enrolled in basic hospital plans; at the beginning of 1959 the number of individuals who had this protection had skyrocketed to 123 million—70 percent of the population. Similar spectacular increases have been recorded in surgical and regular medical programs. In the comparatively new field of major medical insurance, participation in plans offering this protection has virtually exploded from 700,000 in 1952 to 17 million in 1959. It is a source of concern to this committee that no more than a relative handful of Federal employees now have such major medical coverage. This extremely important protection will be made available by the reported bill, along with the more generally prevalent basic coverage which now is held by approximately 70 percent of Federal employees.

COMMITTEE REVIEW OF PROGRAM

The committee emphasizes that the health benefits program provided by this legislation represents an entirely new area of Federal employees' fringe benefits in which the Government is without previous experience, and that extreme care will be necessary, particularly in the initial stages, to protect both the Government and its employees. The committee intends to conduct a continuing review of the operation of the program in order to carry out its responsibilities under section 136 of the Legislative Reorganization Act of 1946.

SUMMARY OF MAJOR PROVISIONS

The reported bill makes basic and catastrophic health protection available to approximately 2 million Federal employees and their dependents. Employees will have free choice among health benefits plans in four major categories, including (1) a Government-wide service benefit plan, such as is offered by Blue Cross-Blue Shield, (2) a Government-wide indemnity benefit plan, such as is currently offered by several insurance companies, (3) one of several employee organization plans, such as the present health plans of the National Association of Letter Carriers and the National Federation of Post Office Clerks, and (4) a comprehensive medical plan, which may be either a group-practice prepayment plan (such as the Kaiser Foundation plan in California and the Group Health Association plan in Washington, D.C.) or an individual-practice prepayment plan (such as the Group Health Insurance plan in New York). The Government-wide service benefit plan and the Government-wide indemnity benefit plan each will include at least two levels of benefits.

The reported bill retains the provisions of the Senate-passed bill (1) providing for 50 percent contribution by the Government to subscription charges and (2) establishing biweekly maximum contributions of $1.75 for an individual employee, $4.25 for an employee and family, and $2.50 for a female employee and family including a nondependent husband.

Employees will be eligible for enrollment in health benefits plans without having to pass any physical examination and, in the event of their separation from Government service, may convert their coverage to a private health benefits plan without undergoing any physical examination. It is intended that each of the foregoing plans will provide a wide range of hospital, surgical, medical, and related benefits designed to afford the employees full or substantially full protection against expenses of both common and catastrophic illness or injury.

Responsibility and authority for administration of the health benefits program in the interest of both the employees and the Government is vested in the U.S. Civil Service Commission. The Commission will execute contracts with the Government-wide service plan carrier and the Government-wide indemnity plan carrier and will make suitable arrangements to place the other types of plans in effect through appropriate contracts or agreements.

Provision is made for the prime insurer under the Government-wide indemnity benefit plan to reinsure with such other qualified companies as may elect to participate, in accordance with an equitable formula.

Similar provision is made for the prime carrier under the Government-wide service benefit plan to allocate its rights and obligations under its contract among such of its affiliates as may elect to participate.

No person will be excluded from participation in the health benefits program because of race, sex, health status, or (at the time of first opportunity to enroll) age.

With respect to the service benefit plan and the indemnity benefit plan, the reported bill requires the Commission to enter into contracts which call for premium rates that are competitive with those generally charged for a new group health insurance sold to large employers. For the premiums agreed upon, the Commission is charged with negotiating the best possible basic health and major medical benefits. These provisions are designed to assure maximum health benefits for employees at the lowest possible cost to themselves and to the Government.

The Government will contribute 50 percent to the subscription charge for each enrolled employee, but not more than certain amounts which the Commission may prescribe from time to time subject to (1) biweekly minimums of $1.25 for an individual employee or annuitant, $3 for an employee or annuitant and family, and $1.75 for a female employee and family including a nondependent husband, and (2) biweekly maximums of $1.75 for an individual employee, $4.25 for an employee or annuitant and family, and $2.50 for a female employee and family including a nondependent husband. The provisions for contributions are related to the service benefit plan and the indemnity benefit plan authorized by section 4 of the bill, thus permitting each employee to exercise independent judgment and obtain the plan which best suits his or her individual needs or family circumstances.

The bill provides for setting aside portions of total contributions (1) not exceeding 1 percent for administrative expenses, and (2) not exceeding 3 percent to provide a contingency reserve or margin for adjustment based on experience without seeking further legislation.

The Commission will make available to each employee eligible to enroll in a health benefits plan information which will enable the employee to exercise an informed choice among the various plans. Each employee will be issued an appropriate certificate summarizing the benefits under the plan selected.

The bill authorizes the Chairman of the Civil Service Commission to appoint an advisory committee of five members, comprising employees enrolled under the act and elected officers of employee organizations. This committee (which will perform a solely advisory function) replaces the Advisory Council which would have been provided by the Senate bill.

The bill omits those parts of the Senate bill which would have (1) established a Bureau of Retirement and Insurance in the Civil Service Commission to administer the health benefits program along with the retirement and life insurance programs, and (2) required prior submission of health benefits contracts to the Post Office and Civil Service Committees of the Senate and the House of Representatives. In the judgment of the committee, the assignment of duties in connection with administration of the program should be left to the

discretion of the Civil Service Commission, which is responsible for success of the program. The committee is convinced that the prior submission of contracts would have tended to impede and interfere with progress in the establishment and operation of the program.

COST

On the basis of the formula, provided by section 7 of the reported bill, for a 50 percent Government contribution subject to certain limitations, the cost of the program for the first year of operation is estimated at $214 million, of which approximately one-half will be paid by the Government.

ADMINISTRATIVE REPORTS

The reports of the Director of the Bureau of the Budget and the Chairman of the U.S. Civil Service Commission (directed to S. 2162 as passed by the Senate and submitted before the committee amendment was drafted) recommend approval of a health benefits program identical in principle to the program which will be established by the bill, as reported by this committee, except that such reports favor a Government contribution of 33⅓ percent in lieu of 50 percent as authorized by the reported bill. The Post Office Department, the Department of Health, Education, and Welfare, the Department of Defense, and the Comptroller General of the United States also submitted reports favorable to the principles of the reported bill.

The committee points out that the Civil Service Commission, the Bureau of the Budget, major employee organizations, and leading companies and associations which now provide health benefits and will participate in this program, have agreed to the terms of the reported bill, in a spirit of compromise and cooperation, in order that an effective and financially sound Government employees health benefits program may become a reality at the earliest possible time. The committee desires to express its appreciation for this cooperation and joint endeavor to bring about a result in the general interest of the Government and all parties concerned. It is believed that the final agreement represented by the reported bill will receive overwhelming approval by Federal employees, full cooperation by the companies and associations which expect to participate, and support of the Government departments and agencies concerned.

The text of the reports of the Bureau of the Budget, the Civil Service Commission, the Department of Defense, the Department of Health, Education, and Welfare, and the General Accounting Office appear immediately following the explanation of the bill, as reported.

Explanation of the Bill, as Reported

SHORT TITLE

The first section of the bill creates a short title which permits the provisions of this legislation to be conveniently cited as the "Federal Employees Health Benefits Act of 1959."

DEFINITIONS

Section 2 defines the technical terms used throughout the act, as follows:

Subsection (*a*) defines the term "employee" to include an appointive or elective officer or employee in or under the executive, judicial, or legislative branches of the U.S. Government and an employee of the District of Columbia government. Included within the definition are Members of Congress, the Official Reporters of Debates of the Senate and their employees, and employees of Gallaudet College. The definition of the term "employee" does not include members of the Armed Forces ("uniformed services") and noncitizen employees whose permanent duty stations are located outside the United States. Also excluded are employees of certain corporations which are under the supervision of the Farm Credit Administration, of which corporations any member of the board of directors is elected or appointed by private interests.

This definition will operate to provide coverage under the bill to the same groups of employees who are covered under the Federal Employees' Group Life Insurance Act of 1954, as amended, except that employees of the Tennessee Valley Authority, who have been specifically excluded from the definition, will not be covered. This exclusion was made at the request of the Tennessee Valley Authority because employees of the Authority have their own contributory health benefits program which has been operating successfully.

Subsection (*b*) defines the term "Government" as meaning the Government of the United States of America to distinguish it from State and local governments.

Subsection (*c*) defines the term "annuitant" to include—

(1) an employee who retires on or after the effective date (July 1, 1960), mentioned in section 15, under the Civil Service Retirement Act or other retirement system for civilian employees, on an immediate annuity after 12 or more years of service or for disability;

(2) a member of a family who receives an immediate annuity as the survivor of a retired employee described in paragraph (1), or an employee who dies after completing 5 or more years of service;

(3) an employee who receives benefits under the Federal Employees' Compensation Act as a result of illness or injury to himself and who because of the illness or injury is determined by the Secretary of Labor to be unable to return to duty; and

(4) a member of a family who receives monthly compensation as the surviving beneficiary of—

(A) an employee who dies of an illness or injury compensable under the Federal Employees' Compensation Act after 5 or more years of service, or

(B) a former employee who dies while receiving compensation benefits and is held by the Secretary of Labor to have been unable to return to duty.

Subsection (*d*) defines the term "member of family" to include—

an employee's or annuitant's spouse;

his unmarried children under age 19, including—

(A) an adopted child, and

(B) a stepchild or recognized natural child who lives with him in a regular parent-child relationship; and

(C) his unmarried children, regardless of age, who are incapable of self-support because of a disability that existed prior to their reaching the age of 19.

Subsection (*e*) defines the term "dependent husband" to mean a husband who is incapable of self-support by reason of mental or physical disability which can be expected to continue for more than 1 year.

Subsection (*f*) defines the term "health benefits plan" as meaning essentially a group insurance policy, contract, agreement, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services.

Subsection (*g*) defines the term "carrier" to include a voluntary association, corporation, partnership, or other nongovernmental organization which provides, pays for, or reimburses the cost of health services under group insurance contracts, agreements, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier. The definition includes a health benefits plan duly sponsored or underwritten by an employee organization.

Subsection (*h*) defines the term "Commission" as meaning the U.S. Civil Service Commission, to which is assigned the responsibility of administering this legislation.

Subsection (*i*) defines the term "employee organization" to include an association or other organization of employees which—

(A) is national in scope or

(B) in which membership is open to all employees of a department or agency of the Government who are eligible to enroll in a health benefits plan

and which on or before December 31, 1959, applies to the Commission for approval of a plan which it sponsors or underwrites.

In addition to the health benefits plans provided by national employee labor organizations, this language would include employee organization sponsored plans such as those of the Federal Bureau of Investigation, the National Security Agency, the U.S. citizen employees of the Panama Canal, the Foreign Service, the Central Intelligence Agency, and the Postal Hospital Association of St. Louis.

ELECTION OF COVERAGE

Section 3 provides generally for election of health benefits plans by employees.

Subsection (*a*) permits an eligible employee to enroll, either as an individual or for self and family, in a health benefits plan approved by the Civil Service Commission. This subsection authorizes the Commission (1) to prescribe regulations fixing the time, manner, and conditions of eligibility for enrollment and (2) to exclude employees from enrolling on the basis of the nature and type of their employment or conditions pertaining thereto such as, but not limited to, short-term appointments, seasonal or intermittent employment, and employment of like nature. However, no employee may be excluded by the Commission's regulations solely on the basis of the hazardous nature of his job.

Subsection (*b*) permits an annuitant to continue his coverage after he retires if he was enrolled in a health benefits plan under the act for a period of not less than (A) the 5 years of service immediately

preceding retirement or (B) the full period or periods of service between the date he first becomes eligible to enroll in a plan and the date on which he becomes an annuitant, whichever is shorter. This subsection also permits the survivor of a deceased employee or annuitant to continue his coverage if the survivor was enrolled as a member of the family at the time of the employee's or annuitant's death.

Where a husband and wife are both Federal employees, subsection (*c*) permits either one to enroll individually or to enroll for self and family and prohibits any person from enrolling both as an employee or annuitant and as a member of the family.

Subsection (*d*) permits an employee or annuitant to change from individual to family coverage or vice versa at such time and under such conditions as the Commission may prescribe.

Subsection (*e*) permits an employee or annuitant to transfer his enrollment from one health benefits plan to another at such time and under such conditions as the Commission may prescribe.

HEALTH BENEFITS PLANS

Section 4 authorizes the Commission to contract for or approve the following health benefits plans:

(1) One Government-wide service benefit plan of the type commonly provided by Blue Cross-Blue Shield under which payment for medical services is made, insofar as possible, under contracts with hospitals, physicians, and other vendors of medical services. Where such payment is impracticable, it will be made directly to the employee.

(2) One Government-wide indemnity benefit plan such as is commonly provided by commercial insurance companies. Under this type of plan payment for medical services may be made directly to the employee or directly to the vendor of the medical services.

(3) Employee organization plans which are sponsored or underwritten by employee organizations. To be eligible under the bill, the organization which sponsors or underwrites the plan must have had in operation a plan which provided health benefits to its members on July 1, 1959. Employees will be able to enroll in these employee organization plans only if at the time of enrollment they are members of the organization.

(4) Two types of comprehensive medical plans—(A) group-practice prepayment plans and (B) individual-practice prepayment plans.

The Government-wide service benefit plan and the Government-wide indemnity benefit plan will each offer two options providing varying levels of benefits at varying subscription charges so that every employee will have an unrestricted choice between the service type plan and the indemnity type plan and, within each plan, between benefits and subscription charges which best suit his family circumstances and his ability to pay.

An employee who belongs to an association which sponsors an employee organization plan will have the additional choice of enrolling in his association's plan. Employees who are located in areas in which a group-practice prepayment plan or an individual-practice prepayment plan operates will have the further choice of enrolling in such a comprehensive medical plan.

TYPES OF BENEFITS

Section 5 stipulates that the benefits to be provided under the plans described in section 4 may be of the following types:

(1) Service benefit plan—
  (A) hospital benefits.
  (B) surgical benefits.
  (C) in-hospital medical benefits.
  (D) ambulatory patient benefits.
  (E) supplemental benefits.
  (F) obstetrical benefits.

(2) Indemnity benefit plan—
  (A) hospital care.
  (B) surgical care and treatment.
  (C) medical care and treatment.
  (D) obstetrical benefits.
  (E) prescribed drugs, medicines, and prosthetic devices.
  (F) other medical supplies and services.

(3) Employee organization plans—
  Benefits of the types described in paragraph (1) or (2) or both.

(4) Comprehensive medical plans—
  Benefits of the types described in paragraph (1) or (2) or both.

The general effect of section 6 is to authorize and require the Civil Service Commission to take appropriate action to contract, or to make other arrangements, for health-benefits plans.

CONTRACTING AUTHORITY

Subsection (*a*) authorizes the Civil Service Commission to negotiate contracts with qualified carriers offering plans described in section 4. The subsection requires each such contract to be for a uniform term of at least 1 year and permits the contract to be made automatically renewable from term to term in the absence of notice of termination by either party.

Paragraph (1) of subsection (*b*) requires the prime carrier for the indemnity benefit plan to be a company which is licensed to issue group health insurance in all the States and the District of Columbia.

Under the related authority to prescribe minimum standards for carriers, vested in the Civil Service Commission by subsection (d), it is expected that one of the standards for the prime indemnity carrier will be the volume of group health insurance business it has handled in the past. The Commission is expected to choose as a prime carrier a company that has by the volume of its operations demonstrated the experience and capacity necessary to handle what will undoubtedly be the largest policy of its kind in the world. In addition to requiring licensing in all the States and the District of Columbia, the Commission will presumably apply some volume-of-business test, such as requiring that the carrier selected shall, in the most recent year for which data are available, have made at least 1 percent of all group health insurance benefit payments in the United States.

Paragraph (2) of subsection (*b*) requires the prime carrier of the indemnity benefit plan to reinsure with such other companies as may elect to participate, in accordance with an equitable formula based on the total amount of their group health insurance payments in the United States during the latest year for which such information is available. The reinsurance formula is to be determined by the carrier and approved by the Commission. Under paragraph (2) the prime carrier for the service benefit plan is similarly required to allocate its rights and obligations among such of its affiliates as may elect to participate, in accordance with an equitable formula which the carrier and its affiliates will determine and which the Commission will approve.

This practice of reinsuring and allocating rights and obligations follows closely the policy laid down by the Congress in the Federal Employees' Group Life Insurance Act of 1954 and ensures that all qualified companies and organizations which are engaged in providing protection against the cost of health services will share equitably in the contracts to be negotiated under this act, if they desire to do so.

Subsection (*c*) requires that any contract negotiated by the Civil Service Commission shall contain a detailed statement of benefits offered and include such maximums, limitations, exclusions and other definition of benefits as the Commission may deem necessary or desirable.

Subsection (*d*) authorizes the Civil Service Commission to prescribe regulations fixing minimum standards for participating health benefits plans and for carriers offering such plans.

Subsection (*e*) prohibits the Civil Service Commission from entering into any contract or approving any plan which excludes employees or annuitants, or members of their families, because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

Subsection (*f*) requires each plan approved by the Commission to permit an employee or annuitant whose enrollment in the plan is terminated, other than by his voluntary cancellation of enrollment, to convert from group coverage to individual coverage. It is expected that when the group coverage of an employee or annuitant terminates, he will have continued temporary protection for 31 days without current contributions so that he may have reasonable opportunity to convert to individual coverage and thus avoid an interruption in his protection against the cost of health services. The terms or conditions under which the employee or annuitant may convert will be prescribed by the carrier and approved by the Civil Service Commission and the employee will have to pay the periodic charges of the converted coverage directly to the carrier.

Subsection (*g*) requires that the converted coverage shall, at the option of the employee or annuitant, be noncancellable by the carrier except for fraud, overinsurance, or nonpayment of periodic charges.

Subsection (*h*) stipulates that the premiums to be charged by the carriers for approved health benefits plans shall reasonably and equitably reflect the cost of the benefits provided. The subsection requires that the premiums for the service benefit plan and the indemnity benefit plan be determined on a basis which, in the judgment of the Civil Service Commission, is consistent with the lowest schedule of basic rates generally charged for new group health benefits plans

issued to large employers. This subsection further requires that premium rates determined for the first contract term shall be continued for subsequent contract terms except that they may be readjusted for any subsequent term based on past experience and benefit adjustments under the subsequent contract. Any readjustment in rates is required to be made in advance of the contract term in which the new rates will apply and on a basis which, in the judgment of the Commission, is consistent with the general practice of carriers which issue group health benefits plans to large employers.

The effect of subsection (*h*) is to make certain that the premiums which the Government will have to pay for the service benefit plan and the indemnity benefit plan will not be more costly than those charged by the industry to other large employers.

CONTRIBUTIONS

Section 7 provides for contributions by the Government and by employees to subscription charges.

Paragraph (1) of subsection (*a*) specifies the Government's contributions to the subscription charge for each enrolled employee and annuitant as the lesser of (A) 50 percent of the subscription charge or (B) such other amounts as the Commission prescribes.

The amounts which the Commission may prescribe, in accordance with clause (B), above, must not (i) be less than $1.25 or more than $1.75 biweekly for an individual who is enrolled for self alone, (ii) be less than $3 or more than $4.25 biweekly for an individual who is enrolled for self and family, or (iii) be less than $1.75 or more than $2.50 biweekly for a female employee who enrolls for self and family if the family includes a nondependent husband.

Paragraph (2) of subsection (*a*) authorizes the withholding from an individual's salary or annuity of the difference between the total subscription charge of the plan in which he is enrolled and the Government's contribution to the subscription charge. The employees' contributions will be made through payroll deductions, as is the case with respect to employees' contributions under the Civil Service Retirement Act and the Federal Employees' Group Life Insurance Act of 1954.

(3) Paragraph authorizes the Civil Service Commission to adjust the contributions of the Government and of the employees and annuitants to a particular plan whenever past experience indicates that such an adjustment is warranted or whenever there is a change in benefits offered by the plan. Any such adjustment must preserve the same ratio between the Government's and employee's or annuitant's contribution as existed originally, with the one exception that the Government's contribution cannot be adjusted to a biweekly amount which is more than the $1.75, $4.25, or $2.50 specified in subsection (*a*)(1).

The net effect of this provision is that the Commission will prescribe the maximum contribution which the Government will make to each approved health benefits plan and so be able to control the total cost of the program to the Government.

It is expected that the Government contributions prescribed by the Commission will be 50 percent of the subscription charge to the approved plans in which most employees are enrolled. Thus the

Government and the employee or annuitant will each contribute 50 percent of the subscription charge.

There may be some plans or options within plans which will provide benefits superior to the benefits under other plans or options and for which the subscription charge per enrollment will exceed the sum of the prescribed maximum Government contribution plus a matching contribution from the employee or annuitant. Where an employee chooses to enroll in such a superior-benefit plan or option, the excess portion of the subscription charge will be withheld from his salary.

Any adjustment in contribution rates must, within the specified limits, preserve the ratio which originally existed between the employee's or annuitant's contribution and the Government's contribution. If in the future an adjustment will (because of the maximums imposed on the Government's contribution) result in destroying this ratio, it is contemplated that the Civil Service Commission will call the matter to the attention of the Congress in advance so that the legislation can be amended to increase the maximum Government contributions if the Congress wishes.

Subsection (*b*) authorizes the Civil Service Commission to continue an employee's coverage for a period of up to 1 year (exclusive of any temporary extension of coverage) while he is in a leave-without-pay status. Because the employee will not be drawing any pay during this period, no contributions can be withheld from his salary and, therefore, the Commission is authorized to waive both the employee's and the Government's contributions while the employee is in a leave-without-pay status.

Subsection (*c*) directs that the Government's contribution toward the cost of the program be paid from the following sources:

(1) For most employees, from the appropriation or fund which is used for the payment of their salaries.

(2) In the case of an elected official, from the appropriation or fund which is available for payment of other salaries of the same office or establishment.

(3) In the case of an employee in the legislative branch whose salary is paid by the Clerk of the House of Representatives, from the contingent fund of the House.

Subsection (*d*) directs the Civil Service Commission to provide for the conversion of the biweekly contribution rates to weekly, monthly or other rates in the case of individuals who are paid on other than a biweekly basis and permits the converted rate to be adjusted to the nearest cent.

EMPLOYEES' HEALTH BENEFITS FUND

Subsection (*a*) of section 8 creates an employees health benefits fund, to be administered by the Civil Service Commission, which is made available without fiscal year limitation for the payment of all premiums to approved health benefits plans and into which all contributions of employees, annuitants, and the Government shall be paid.

Subsection (*b*) requires that portions of the contributions made by employees, annuitants, and the Government shall be regularly set aside in the fund as follows:

(1) A percentage, not to exceed 1 percent of all such contributions, determined by the Commission as reasonably adequate to pay its administrative expenses under this bill.

(2) For each health benefits plan a percentage, not to exceed 3 percent of the contributions for such plan, determined by the Commission as reasonably adequate to provide a contingency reserve. It is expected that these contingency reserves will be available to defray anticipated increases in future premiums and it is hoped that their use in this manner will postpone for a reasonable period of time the necessity of increases in contribution rates. Authorization is also contained in this subsection for applying the contingency reserves to reduce the contributions of employees and the Government or to increase the benefits provided by the plan from which the reserves are derived. It is required that the contingency reserves set aside for each plan will be used for the purposes mentioned above with respect to that plan only.

Subsection (*c*) authorizes the Secretary of the Treasury to invest any of the moneys in the employees health benefits fund in interest-bearing obligations of the United States and to sell such obligations for the purposes of the fund. All interest derived from these investments and the proceeds from the sale of obligations will become a part of the fund.

ADMINISTRATIVE EXPENSES

Subsection (*a*) of section 9 authorizes the expenditure from the employees' life insurance fund for the fiscal years 1960 and 1961, without regard to limitations on that fund, of such sums as may be necessary to pay the administrative expenses of the Civil Service Commission in carrying out the provisions of the Federal Employees Health Benefits Act of 1959. The subsection requires that reimbursement for sums so expended be made from the employees' health benefits fund to the employees' life insurance fund, together with interest at a rate to be determined by the Secretary of the Treasury.

Subsection (*b*) makes the employees' health benefits fund available (1) to reimburse the employees' life insurance fund, as indicated and (2), within such limitations as may be specified annually by the Congress, to pay the expenses of the Commission in administering this legislation for the fiscal year 1962 and subsequent years.

ADMINISTRATION

Subsection (*a*) of section 10 authorizes the Civil Service Commission to promulgate such regulations as may be necessary to give effect to the intent and purposes of the Federal Employees Health Benefits Act of 1959.

Subsection (*b*) requires the Civil Service Commission to specify in its regulations the beginning and ending dates of coverage of employees and annuitants and members of their families. The subsection permits the Commission, by regulation, to grant a temporary extension of coverage upon cancellation (other than voluntary cancellation) of enrollment. Where the cancellation is for reasons other than the death of the employee or annuitant, it is expected that the temporary extension of coverage will continue for 31 days. Where the cancellation is on account of the death of the employee or annuitant, this subsection permits a temporary extension of coverage for members of the family for as long as 90 days after the end of the pay period or month in which the death of the employee or annuitant occurred. In any case, it is intended that the temporary extension of coverage will be

without current contributions by the employee or annuitant, or members of his family, and by the Government.

Subsection (*c*) provides that an employee enrolled under this legislation who is removed or suspended without pay and later reinstated or restored to duty because the removal or suspension was unjustified or unwarranted shall have his coverage restored so that he may enjoy the same benefits as if removal or suspension had not occurred.

Subsection (*d*) requires that the Civil Service Commission shall make available to each employee such information as may be necessary to enable him to exercise an informed choice among the various plans available. This information with respect to the Government-wide service benefit plan and the Government-wide indemnity benefit plan must be in a form acceptable to the Commission and will be developed by the Commission after consultation with the carriers. It is expected that information with respect to the employee organization plans and the comprehensive medical plans will be prepared and distributed by the respective carriers; however, this information must also be approved by the Commission. Each employee who enrolls in a health benefits plan will be issued an appropriate certificate summarizing the services or benefits provided by the plan. These certificates will also have to be approved by the Commission.

STUDIES, REPORTS, AND AUDITS

Subsection (*a*) of section 11 stipulates that the Civil Service Commission shall make a continuing study of the operation and administration of this legislation, including surveys and reports on health benefits plans available to employees and on the experience of such plans. It is expected that in making this study the Commission will include any instances of apparent overutilization of hospital facilities and any instances of apparently excessive charges by purveyors of health services.

Subsection (*b*) requires carriers to furnish such reports as the Civil Service Commission determines to be necessary to enable it to carry out its functions under this legislation and permits the Commission and representatives of the General Accounting Office to examine any records of the carriers which either the Commission or the General Accounting Office deem to be pertinent to the purposes of this legislation.

Subsection (*c*) requires Government departments, agencies, and independent establishments to keep such records, make such certifications, and furnish the Civil Service Commission such information and reports as may be necessary to enable the Commission to carry out its functions under the legislation.

REPORTS TO CONGRESS

Section 12 requires the Commission to transmit to the Congress an annual report concerning the operation of the Federal Employees Health Benefits Act of 1959.

ADVISORY COMMITTEE

Section 13 requires the Chairman of the Civil Service Commission to appoint a committee composed of five members, who will serve

without compensation, to advise the Commission regarding matters of concern to employees under this legislation. Each member of the committee will be an employee enrolled under this legislation, or an elected officer of a national employee organization.

JURISDICTION OF COURTS

Section 14 gives the district courts of the United States original jurisdiction, concurrent with the Court of Claims, of any civil action or claim against the United States founded upon this legislation.

EFFECTIVE DATE

Section 15 makes the benefit and contributions provisions of this legislation effective on the first day of the first pay period which begins on or after July 1, 1960, and, by implication, makes the other provisions of the legislation effective upon enactment.

Administrative Reports

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., August 4, 1959.

Hon. TOM MURRAY,
Chairman, Committee on Post Office and Civil Service,
House of Representatives, Washington, D.C.

MY DEAR MR. CHAIRMAN: Reference is made to your letter of July 8, 1959, requesting the views of the Bureau of the Budget on S. 2162, to provide a health benefits program for Government employees, presently before your committee.

Since 1954 this administration has advocated, and now continues to advocate, the establishment of a voluntary health insurance program for Federal employees. Specific programs were proposed in 1954, 1955, 1956, and 1957, each proposal being an attempt to formulate a better program. In 1958 the administration gave priority to pay increase legislation and recommended that action on employee health insurance legislation be postponed. It should be noted that during these years Government annual expenditures for Federal employee pay and benefits have been increased by substantial amounts due to increases in pay rates under both the statutory and prevailing wage systems, increases in annuities under employee retirement systems, the liberalization of the premium pay benefits system, the liberalization of the civil service retirement system and the establishment of such new benefits as the allowances for uniforms and the group life insurance and unemployment compensation systems.

Following this administration's basic policy that the Federal employee should be compensated for the services he renders to the Government under a pay and benefit system that is reasonably comparable in structure and level with the compensation provided by progressive private employers, the Bureau of the Budget favors legislation authorizing a Federal employee health insurance program with benefits providing financial protection against the cost of health care reasonably comparable with those benefits provided in private employment. Although the existing Federal employee fringe benefit

system has been reported to be already more liberal than the typical private business fringe benefit system, it does not include a program of health insurance benefits. Adding these benefits to the existing system will further increase the total value of the Federal employee fringe benefit package. Under these circumstances it is essential that the value added by the new health insurance benefit program be kept in line with private industry health benefits.

The new health insurance benefits should be made available only to employees who earn them by rendering services to the Government under the new program after it becomes effective. Compensation in the form of pay and benefits is paid to employees for services rendered. Former employees who rendered service under a compensation system which did not include these health insurance benefits have already been paid in full for their services in the form of pay and benefits already received or in vested rights to payment of future benefits already earned. Whenever salary or benefits are adjusted an effective date must be selected. It may be unfortunate that some former employees must miss eligibility by narrow margins, and a retroactive approach is often suggested. However, a retroactive approach actually creates an inequity where none would otherwise exist. For while prospective entitlement is firmly linked to services rendered under a compensation agreement, retroactive entitlement is pure gratuity. If any former employee is granted this special gift, then any other former employees who are excluded by the particular retroactive date selected will feel they merit equal consideration. The new health insurance benefits should, therefore, be provided only to employees who render service to the Government after a prospective effective date.

S. 2162, now before your committee, while including several desirable features, falls short of providing an acceptable employee health insurance program in two major respects: the cost to the Government is higher than justifiable in establishing a health insurance benefits program reasonably comparable with existing private business programs, and the organization and administrative system is defective.

The cost-sharing feature of the bill would require the Government to pay one-half of the premiums rather than one-third, as established for the Federal employee group life insurance program in 1954. The first-year cost of the bill to the Government is estimated in the Senate committee report to be $145.3 million, which must be increased by $2.5 million in the first year and $25 million in the fifth year to include the Government share of the cost of annuitant coverage. This amount is substantially higher than the $80 million figure which is actually needed as one-third of the cost, including the cost of annuitant coverage, of a sound program providing a benefit level in line with private industry plans, and providing a sound experience basis for accumulating the facts on which an appropriate Federal employee health benefits program can evolve for the future. It would be prudent for the Government to seek the patterns and level of health benefit protection best suited to the problems of the Federal employee, the benefits that will yield the most effective return for the premium dollar. Experience elsewhere strongly suggests that an effective program will evolve best from a conservative base. Sound development can occur as the genuine needs of the covered employees are clearly defined through experience, and a pattern of effective health care benefits grows up to meet

these needs. The bill should be modified to clearly provide this sound, conservative beginning.

The organization and administrative provisions of S. 2162 should be modified. The Civil Service Commission will advise you in full detail concerning these modifications. This report will comment only on three organization provisions: the advisory council, the Civil Service Commission reorganization, and the submittal of proposed contracts and regulations.

The functions and membership of the proposed advisory council are not designed to aid sound administration. The council's assigned functions include making investigations of the administration of the program, and receiving reports direct from carriers and employees. Such assignment would confuse the Commission's authority in its relations with carriers, employing agencies, and employees. The Civil Service Commission should be unmistakably responsible for the success of this program. The council's functions should be advisory only. The council's membership should reflect its character as an element of a Federal employee benefit program, and should include appropriate Government officials, ex officio, together with employees, or their representatives, who are contributing and participating in the health insurance system. There is no need to create a statutory organization based on an assumption that the Civil Service Commission may refuse to seek the advice of responsible experts in the health insurance field. Neither is there basis for assuming that the Commission may foster a program which will be deleterious to the public generally, nor that the Commission will fail to give adequate consideration to all parties, including all qualified prospective carriers. The Government's lack of experience in administering a health insurance program for its employees and the asserted absence of facts upon which to base decisions does not argue for splitting responsibility in this program between the Civil Service Commission and the advisory council. Rather, it requires placing a special responsibility on the Commission to proceed prudently, to develop factual experience as rapidly as feasible, and to build soundly, and it places a special responsibility on those who contribute to the design of the authorizing statute to provide the clear-cut authority and proper organization that will be so essential. Section 12 should be modified accordingly.

The proposed statutory reorganization of the Civil Service Commission would interfere, to no defined purpose, with the existing statutory power and responsibility of the Chairman of the Civil Service Commission to determine the internal organization of the Commission's business and to designate officers and employees to perform assigned functions. It is especially important in this new program to avoid a rigid organization prescription that could hamper the proper adjustment of administration with experience. Section 13 should be deleted from the bill.

The requirement that the Commission submit proposed contracts and regulations to the Senate and House Committees on Post Office and Civil Service is unnecessary to assure energetic administration by the Commission and is clearly improper if it is intended to provide the committees with a power of prior review of executive action. Subsection (a) of section 16 should be deleted from the bill.

S. 2162, as passed by the Senate, includes several features which are desirable in a program of Federal employee health benefits, but

it seeks to provide a level of benefits at an unnecessarily high cost, and it provides an unsound system and organization for administration. Unless S. 2162 is modified as to cost and administrative provisions, as above noted, the Bureau of the Budget would not favor enactment of the bill.

Sincerely yours,

MAURICE H. STANS, *Director.*

CIVIL SERVICE COMMISSION,
August 5, 1959.

Hon. TOM MURRAY,
Chairman, Committee on Post Office and Civil Service,
House of Representatives.

DEAR MR. MURRAY: In response to your letter of July 8, 1959, I am forwarding the Commission's views on the bill S. 2162, to provide a health benefits program for Government employees, as the bill has been amended by the Senate Post Office and Civil Service Committee and reported to the Senate. These views would also apply to H.R. 8210 and H.R. 8211, which are identical to S. 2162.

In the interest of brevity we are not here including a section analysis of S. 2162. The Senate committee's report of July 2, 1959, (No. 468) contains an explanation of the bill by sections. Except as noted hereinafter, the Commission construes the bill as stated in that explanation.

As the central personnel agency of the executive branch, the Commission considers enactment of a health insurance program for Federal employees highly desirable. Such a program would fill the one remaining major gap in employee fringe benefits and be of inestimable value in attracting and retaining Federal personnel.

We are in complete agreement with the fundamental concepts underlying S. 2162. Very briefly, these would—

(1) Permit employees a free choice among a Government-wide service benefit plan, a Government-wide indemnity benefit plan, a local group practice prepayment plan, and an employee organization plan.

(2) Require contributions from the employee and from the Government.

(3) Make the Commission responsible for the overall administration of the program while sharing the day-to-day operating responsibilities with the employing agencies and the insurance carriers.

(4) Create a central fund into which all receipts would be deposited and out of which all disbursements would be paid.

The soundness of these same concepts (except for the first, which is pertinent only to health insurance) has been solidly established by the efficient operation of the Federal employees' group life insurance program.

The Commission does not, however, altogether favor the manner in which S. 2162 applies these four general principles. We also have serious reservations about several other provisions of the bill. Under the circumstances, we find S. 2162 sufficiently objectionable to compel

as to report unfavorably. If the objectionable features were corrected, we would find the bill acceptable and a good basis for a successful, enduring health benefits program.

There follows a discussion of what we consider to be the objectionable features of the bill, together with suggestions for rectifying them.

RETROACTIVITY

Regardless of how long before July 1, 1960, S. 2162 were enacted, it would become generally effective no earlier than that date. Section 2(b)(2), however, contains a proviso which would extend the benefits of the bill to certain employees and certain survivors who qualify for annuity between the time the bill is enacted and the time it becomes generally effective.

We appreciate and are not unsympathetic with the purpose of this proviso which is to protect those people who would otherwise be denied the benefits of the bill because, owing to circumstances beyond their control, they are separated before its effective date.

The situation which the proviso in section 2(b)(2) seeks to cure is not new. It occurs each time beneficial legislation is enacted and on each such occasion it appears that numbers of people have been denied benefits because they were prematurely separated. Depending largely on the value of the benefit, the group which considers itself aggrieved by having been denied the benefits ranges all the way from those who were separated as little as 1 day too early to those who were separated as much as 5 or even 10 years too early.

It is unfortunate that any person has to be denied a benefit because he has been prematurely separated, but we know from long experience that the proviso in section 2(b)(2), although it may slightly lessen the number of persons who will feel aggrieved, will not appreciably remedy the situation. The proviso in section 2(b)(2) would extend health benefits to certain employees who retire involuntarily or for disability during the interval between the enactment and effective date of the bill and to survivors of certain employees who die during this interval. The number of people whom the proviso will affect will depend on how long this interval may be, but in any event the proviso will not affect the large number of employees who, for example, will voluntarily retire during the interval and later claim they had no knowledge of the fact that, had they waited, they could have qualified. Nor, for another example, will it affect the even larger number of employees who retired (or died) 1 day, 1 week, 1 year before the enactment date.

A line of demarcation must be drawn somewhere. The fairest and firmest place to draw the line is at the date the enacted bill becomes effective. Any retroactivity, unless it were complete, would be discriminatory and would intensify the aggrievement the excluded groups would feel and the representations they would make for having the benefits extended to them. The Commission, therefore, recommends that the following text be deleted from the bill:

(1) Subsection 2(b)(2) on page 23, beginning in line 13 and ending in line 18.

(2) Subsection 3(b)(2) beginning on page 26, line 25, and ending on page 27, line 11.

BENEFITS AND CONTRIBUTIONS

There are at least two aspects of the bill's benefit-contribution structure which, in the Commission's view, are so objectionable as to make S. 2162 unsatisfactory. These aspects are as follows:

(1) Government contributions:

At the maximum rates specified in section 7(a), the total contribution required of the Government has been estimated by the Senate committee at $145.3 million annually. We would make two observations concerning this estimate: First, it does not include the sums which the Government would have to contribute annually toward insuring annuitants; second, the administration's frequently stated position is that it cannot at this time acquiesce in spending more than $80 million a year on this program.

(2) Contributions versus benefits:

It can be contended that under section 7(a) contributions of employees and Government may be kept low by setting the rate at a figure less than the maximum authorized amount. But, we are not aware that any carrier has submitted a firm offer to underwrite, at a price less than the maximum contribution rates, the ultrarich benefits which are described in section 5(a)(1) and which are further implied in the Senate committee's report on S. 2162.

In the absence of such firm offer, we have reservations as to whether the implied benefits can be contracted for even at the maximum contribution rates. To the extent that they cannot, or to the extent that Government fiscal policy requires the contribution rates to be set lower than the maximum, the implied ultrarich benefits will have to be curtailed. Any such curtailment in benefits will, like the too-high contribution rates, result in employee disaffection with the program.

We discern other weaknesses in the benefit-contribution structure of S. 2162 but those mentioned above are considered sufficient to justify our recommendation against enactment.

In the absence of a written commitment from a reputable carrier containing detailed specifications of benefits and subscription charges, we believe it wiser not to mislead employees into believing that they will receive ultrarich benefits. It would be infinitely better to delete section 5 of the bill in its entirety and rely on the Commission to negotiate contracts which will provide employees with generally better benefits than they now can get, at a cost to them which, depending on the geographic area, may be less than or about the same as they now pay.

We believe that, to assure enactment of a program, section 7(a) should limit the Government's total contribution to an amount which is acceptable to the administration. And, further, to permit employees who may be so inclined to enroll in plans offering very rich benefits (e.g., some existing group-practice plans) at a subscription charge greater than the maximum contribution rate stipulated in section 7(a), no limit on the employee's contribution rate should be specified. Suggested language to accomplish both these points follows:

"SEC. 7(a)(1) The Government's contribution to the subscription charge for each enrolled employee or annuitant shall be 33⅓ per centum of the subscription charge but may not exceed (i) 95 cents biweekly if he is enrolled for himself alone, or (ii) $2.30 biweekly if he is enrolled for himself and members of his family, or (iii) $1.35 biweekly in the case of a female employee or annuitant who is enrolled for herself and members of her family, including a nondependent husband.

"(2) There shall be withheld from the salary of each employee or annuity of each annuitant enrolled in a health benefits plan under this Act so much as is necessary, after deducting the Government's contribution, to pay the subscription charge for his enrollment."

CONTRACTING AUTHORITY

Section 6 authorizes the Commission to negotiate contracts with qualified carriers. It enumerates some of the items to be specified in the contracts but offers no guidance—nor does the Senate committee's report on S. 2162—on what we regard as a critical issue: Should each carrier of a Government-wide plan assume the total risk under his contract or should he be required to share his rights and obligations with other insurers?

For several reasons, but primarily to simplify negotiations with prospective carriers, the Commission considers it highly desirable that the prime carriers' rights and obligations under the two Government-wide plans be shared in much the same manner as the Congress has provided under the Federal Employees' Group Life Insurance Act. While the Commission, in contract negotiations, would probably insist on such sharing even if section 6 were enacted in its present form, it would be preferable to have the Congress express its intent in this regard by including language along the following lines in section 6, perhaps as a new subsection (b):

"(b)(1) The contract for the Government-wide service benefit plan shall require the carrier to allocate its rights and obligations under the contract among all its affiliates who elect to participate in accordance with an equitable formula to be determined by the carrier and its affiliates and approved by the Commission.

"(2) To be eligible as the carrier for the Government-wide indemnity benefit plan, a company must be licensed to issue group health insurance in all the States and the District of Columbia. The policy for such plan shall require the carrier to reinsure with such other companies as may elect to participate, in accordance with an equitable formula based on the total amount of their group health insurance claims paid in the United States during the latest year for which such information is available, to be determined by the carrier and approved by the Commission."

The Commission assumes, of course, that the national Blue Cross-Blue Shield organization will be the prime carrier for the Government-wide service benefit plan. To eliminate all but a dozen or so of the largest, most responsible insurance companies from consideration as prime carrier of the indemnity benefit plan, and to avoid diversity of citizenship difficulties in the event of a court action by an employee, the suggested language requires the prime carrier to be licensed in all the States and the District of Columbia. All other companies which write group health insurance would, of course, be eligible to acquire their fair share of reinsurance from the prime carrier.

HEALTH BENEFITS FUND

I am sure your committee is aware that increasing use of hospital and other health services and the continuing rise in the cost of these services has required many insuring organizations to raise their subscription or premium rates. Some organizations have had to raise their rates several times within the last few years. The current situation in New York City, where the Blue Cross has very recently announced a substantial increase in its rates for the second time in less than 2 years, is characteristic of the trend toward higher insurance costs. Also characteristic is the reported widespread disatisfaction with the rate increases among subscribers.

Informed opinion is to the effect that steady increases in the cost of providing health services are inevitable. To avoid the necessity of having to increase contribution rates under the Government-sponsored program with unnecessary frequency and, incidentally, to avoid the employee dissatisfaction and the administrative difficulties entailed in each such rate increase, the Commission believes that an adequate contingency reserve should be set aside which could be drawn upon to stave off frequent contribution rate increases. Section 8 of S. 2162 makes no provision for setting aside funds for this purpose other than those derived from "dividends, premium rate credits or other refunds." These refunds (and there is nothing to guarantee that any will be made by the carriers) are completely inadequate for use as a contingency reserve.

The Senate committee, in page 18 of its report on S. 2162, seems to have recognized the need to stabilize contributions by setting aside a portion of contributions as a reserve. It indicates that the reserve shall "not * * * exceed approximately 3 percent of any one year's contributions or [exceed] an accumulative total of approximately 10 percent." However there is no language in section 8 which would authorize retention of any portion of the contributions as a reserve, much less the specific percentages indicated in the Senate committee's report. In view of the explicit authorization in section 8 to set aside a 1 percent reserve for administrative expenses, we question the propriety of setting aside a larger contingency reserve without explicit authorization.

Increases in the cost of health services cannot, of course, be forecast with precision over a long period of years. The Commission feels rather strongly, however, that a contingency reserve should be accumulated which will be adequate to stave off increases in contribution rates for at least the first 5 years of the program's existence and, if possible, longer. To the best of our ability, we have estimated that to do this, it will necessary to set aside moneys up to a maximum of 10 percent of all contributions paid into the fund. Suggested language for amending section 8 to permit the setting aside of an adequate reserve follows:

SEC. 8. (a) There is hereby created a Federal Employees Health Benefits Fund, hereinafter referred to as the "Fund," which is hereby made available without fiscal year limitation for the payment of all subscription charges or premiums under contracts or policies entered into or purchased under section 6. The contributions of employees, annuitants, and the Government toward the subscription charges shall be paid into the Fund.

"(b) Portions of the subscription charges contributed by employees, annuitants, and the Government shall regularly be set aside as follows: (1) a percentage, not to exceed 1 per centum of all such contributions, determined by the Commission as reasonably adequate to pay the administrative expenses made available in section 9; (2) for each plan, a percentage, not to exceed 10 per centum of the contributions toward such plan, determined by the Commission as reasonably adequate to provide a contingency reserve. The income derived from any dividends, premium rate adjustments, or other refunds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future subscription charges, or may be applied to reduce the contributions of employees and the Government to, or to increase the benefits provided by, the plan from which such reserves are derived, as the Commission shall from time to time determine.

"(c) The Secretary of the Treasury is authorized to invest and reinvest any of the moneys in the Fund in interest-bearing obligations of the United States and to sell such obligations of the United States for the purposes of the Fund. The interest on and the proceeds from the sale of any such obligations shall become a part of the Fund."

ADVISORY COUNCIL

The Commission believes that an advisory council can be a valuable adjunct to the health insurance program. Conversely, a council could operate to hamper administration of the program.

In our considered opinion, two features of section 12 will seriously impair efficient operation of the program.

(1) Composition:

The 11-member Council called for by S. 2162 is so large as to inhibit unified and timely action which may be required of it.

Of the members mentioned in clauses (1) through (7) of section 12(a) only the Director of the Bureau of the Budget, because he is concerned with Government fiscal policy, and the three representatives of employee organizations have a continuing intrinsic interest in the program. We do not see that the other members mentioned (the Secretary of Labor, the Surgeon General, the Chief of the Bureau of Medicine and Surgery, a representative of the public, and three representatives of universities) have more than a casual interest in or concern with the program nor what long-range purpose would be served by their permanent membership on the Council. In any event, the services and advice of any or all these persons could be readily obtained when, in a particular situation, it was considered desirable.

We would suggest that section 12 be amended to create a smaller, more efficient Council whose membership would be representative of the vital interests affected by the program. This membership should, in our opinion, consist of the Director of the Bureau of the Budget, the Secretary of the Treasury, because he is charged by S. 2162 with the management of the health benefits fund, the Secretary of Health, Education, and Welfare, because he is officially concerned with public health and health benefits and, finally, to represent employees' interests, two elected officers of employee organizations and two insured employees at large.

(2) Duties:

Three of the Council's duties prescribed by section 12(b) are sufficiently inappropriate for an *advisory* council to repeat and comment on here:

(a) "to make studies from time to time of the operation and administration of this Act."

This prescribed duty is sheer duplication of what the Commission is required to do by section 11(a)—"[to] make a continuing study of the operation and administration of this Act."

(b) "to receive reports and information with respect [to this Act] from the Commission, carriers and employees and their representatives."

This duty will (1) interpose the Council between the Commission and the carriers and impair the carriers' accountability to the Commission and (2) make the Council a forum for airing employee grievances. Even if S. 2162 did not require it, the Commission would, as a matter of course, furnish reports and information to the Council and otherwise keep it current with developments so that it would have a basis on which to furnish advice and make recommendations.

(c) "to ascertain from time to time the status of the Federal Employees Health Benefits Fund, including the establishment and maintenance of any balances and reserves."

The Commission, as trustee of the fund, would do just this on a continuing basis and its efforts in this regard would automatically be audited by the General Accounting Office.

We cannot help but feel that, especially at the outset of the program, the Advisory Council as constituted by section 12 would have to be in virtually continuous session, would divert the energies and resources of the Commission, and, in general, would impede efficient administration. We urge that section 12 be amended so that it provides for a council whose function will be to advise and to recommend rather than to monitor the Commission. Language which would do this follows:

"SEC. 12. (a) There is hereby established a Federal Employees Health Benefits Advisory Council which shall consist of the following:

"(1) The Director of the Bureau of the Budget or his representative;

"(2) The Secretary of the Treasury or his representative;

"(3) The Secretary of Health, Education, and Welfare or his representative;

"(4) Four members, to be appointed by the Chairman of the Commission, of whom two shall be elected officers of national employee organizations and two shall be employees enrolled under this Act.

"(b) It shall be the duty of the Advisory Council (1) to consult with and advise the Commission in regard to the administration of this Act, and (2) to make recommendations to the Commission with respect to the amendment of this Act or improvements in its administration.

"(c) Members of the Council who are not otherwise in the employ of the United States shall be entitled while attending meetings of the Advisory Council, including travel time, to receive compensation at

a rate to be fixed by the Commission, but not exceeding $50 per diem, while away from their homes or regular places of business.

"(d) The Advisory Council shall be convened once yearly or oftener on the call of the Chairman of the Commission or on request of any three members of the Advisory Council."

STATUTORY BUREAU OF RETIREMENT AND INSURANCE

The only reasons we know of for the inclusion of section 13 in S. 2162 are the ones advanced in page 19 of the Senate committee's report on the bill. To put it briefly, the Commission does not find these reasons persuasive.

It is quite possible that the Commission may find it advisable to organize a bureau to handle its retirement and insurance functions. This possibility exists whether S. 2162 is enacted or not. The Chairman of the Commission is already empowered by law to reorganize the Commission and if considerations of economy and efficiency should in the future so dictate, he would do this. But his right, among other things, to choose a propitious time for the reorganization, to assign a name to a newly created bureau, to delegate responsibility, and to determine, in accordance with position classification standards, the grade of a bureau director should not be invaded by a statute which is not germane to these matters.

We must strongly urge that section 13 be deleted entirely from S. 2162.

CONTRACTS AND REGULATIONS

The last feature to which the Commission feels obliged to object is the directive in section 16(a) which would require the Commission to transmit by May 1, 1960, to the House and Senate Committees on Post Office and Civil Service, copies of the contracts it proposes to enter into and the regulations it proposes to promulgate.

We cannot perceive nor have we been able to ascertain the purpose of this directive unless it is to assure that the Commission takes timely action to implement the enacted bill. If this is its purpose, its inclusion in the bill is superfluous since section 16(b) directs that the enacted bill become effective July 1, 1960. If the bill is enacted, we will of course deploy all our resources to have implementation completed by that date. We feel, in this connection, that it is necessary only to call attention to the very prompt action the Commission took in August of 1954 to make the Group Life Insurance Act effective—and this with no effective date specified in the statute.

In addition to being superfluous, section 16(a) would leave the Commission in a quandary in at least two respects.

(1) Prudence would seem to dictate that the Commission, having transmitted copies of the contracts and the regulations, postpone their signing and promulgation while it awaited some formal acknowledgement from both the Senate and House committees that they had objections to or that they approved of the proposed contracts and regulations. The wait could of course result in significant delay but any action, either negative or affirmative, on the part of either committee could be construed as an infringement upon the Executive's powers.

(2) If between the time copies of the contracts and the regulations were transmitted and the time they were signed and promulgated, changes were made in either or both, the Commission would presumably have to notify the committees of the changes and again await acknowledgements. Such last minute changes could easily occur after May 1, 1960, in which case the Commission could, involuntarily, be in violation of section 16(a).

Viewed in the most favorable light, section 16(a) is superfluous and enigmatic. It should be deleted from the bill.

We are not in this statement of our views suggesting language to perfect a number of relatively minor items in S. 2162 which we think can (and should) be easily improved. Mostly, these improvements would facilitate administration of the program.

I would be glad to have a representative of my office meet with your staff to work out these perfecting changes and, if you wish, to provide such other technical assistance as your committee may want.

The Bureau of the Budget advises that there is no objection to the submission of this statement to your committee.

By direction of the Commission:

Sincerely yours,

ROGER W. JONES, *Chairman.*

OFFICE OF THE POSTMASTER GENERAL,
Washington, D.C., July 28, 1959.

Hon. TOM MURRAY,
Chairman, Committee on Post Office and Civil Service,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Reference is made to your request for the views of this Department on S. 2162, as amended and reported in the Senate. S. 2162 is a bill to provide a health benefits program for Government employees.

In previous years the Post Office Department has favored in principle health insurance for Federal employees, provided such insurance could be obtained at a reasonable cost and meets the needs of employees for protection against catastrophic illness. This Department continues to favor such health insurance for Federal employees.

S. 2162 as reported in the U.S. Senate is based on a committee print. The position of the administration on this legislation has been set forth in reports by the Civil Service Commission and by the Bureau of the Budget (pp. 24–28 of S. Rept. 468 to accompany S. 2162). These reports have been brought to the attention of this Department and this Department concurs therein.

It is understood that the U.S. Civil Service Commission and the Bureau of the Budget will file reports with your committee with respect to S. 2162 as reported to the Senate. In the circumstances, this Department has no comments or recommendations to submit with respect to this legislation.

The Bureau of the Budget has advised that there would be no objection to the submission of this report to the committee.

Sincerely yours,

E. O. SESSIONS,
Acting Postmaster General.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
August 12, 1959.

Hon. TOM MURRAY,
Chairman, Committee on Post Office and Civil Service,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in reply to your request of July 8 for our comments on S. 2162, as passed by the Senate, a bill to provide a health benefits program for Government employees.

Our comments on S. 2162 are also applicable to H.R. 8210 and H.R. 8211, pending before your committee, which appear to be identical with S. 2162.

In view of the detailed explanation of S. 2162 in the report of the Senate Committee on Post Office and Civil Service, we refrain from burdening this report with a summary of the bill.

The pattern of health insurance coverage for Federal employees proposed by this bill is one which this Department considers appropriate and essential, both to meet the health insurance needs of Federal employees and to assure the competition among plans necessary for expansion of voluntary health insurance in the Nation. In this connection, we should like to mention the following basic points:

1. The employee options permit a real choice of coverage by the employee in terms of what he considers best suited to his needs and those of his family, and also provide an opportunity for the development of enrollment procedures which will yield the kind of educational efforts required to promote restraint and responsibility in the use of health insurance benefits. Carriers have found such efforts necessary with regard to both the insured and the providers of services.

Employee choices call for reasonable opportunity for changing from one plan to another. If the rules regarding transfer from one plan to another are unduly restrictive, a valuable gage of employee satisfaction and carrier performance can be lost. Since the bill forbids restrictions which would exclude or limit coverage for preexisting diseases or conditions, the main problems in working out reasonable transfer arrangements will be adjustments for premium payments and benefits already availed of during the previous part of the benefit year.

2. The alternative types of plans set forth in the bill permit the development of benefits which could provide full scope of protection for Federal employees. It should be the responsibility of the Commission to see that each of the plans for which it contracts or gives approval offers protection which is substantially equivalent to some desirable level established by the Commission as a yardstick. Important, too, is the opportunity provided under the bill for women employees to gain coverage for their families.

3. The bill accepts the principle of uniform contributions for both active employees and retirees and uniform benefits for these groups. The continuation of protection for retired employees without reduction—with premiums to continue at the same level, and their cost to be shared by the annuitant and the Government in the same proportion, as for active employees—follows a desirable pattern of coverage in health insurance plans generally.

4. The bill permits the setting aside of a portion of the health benefits fund as a special reserve against adverse fluctuations in future charges. A reserve of this type appears wholly appropriate in view

of the nature of health benefits risk and the rising trend in medical care costs.

On such matters as the desirable distribution of premium costs as between the Government and employees, the composition and functions of the Advisory Council, and the proposed establishment of a Bureau of Retirement and Insurance within the Commission, we defer to the views of the Civil Service Commission. We suggest, however, that the Secretary of Health, Education, and Welfare be designated as a member of the Council in place of the Surgeon General of the Public Health Service. It should be noted that our Social Security Administration and the Office of the Special Assistant to the Secretary on Health and Medical Affairs, as well as the Public Health Service, are expert in and concerned with the study and encouragement of voluntary prepayment plans for hospital, medical, and other health services.

We, therefore, recommend enactment of the bill, with the modifications above suggested, and with such further modifications as are indicated by the views of the Civil Service Commission and the Bureau of the Budget, on the Federal share of the costs, on administrative organization, and on the composition and functions of the Advisory Council.

In making this recommendation, we have not overlooked the fact that the bill does not address itself to the problem of health insurance for those who are already retired, a fact that has given us much concern. We consider it essential that legislation for active employees and future retirees be supplemented in the near future by providing similar protection for those already retired. While we recognize the complexity of the problems involved in providing effective health benefit coverage to those already on annuities, the pressing health insurance needs of retired Federal employees suggest the importance of an early formulation of ways and means to meet their problems.

The Bureau of the Budget advises that it perceives no objection to the submission of this report to your committee.

Sincerely yours,

ARTHUR S. FLEMMING, *Secretary.*

GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE,
Washington, D.C., August 7, 1959.

Hon. TOM MURRAY,
Chairman, Committee on Post Office and Civil Service,
House of Representatives.

DEAR MR. CHAIRMAN: Reference is made to your request for the views of the Department of Defense on S. 2162, 86th Congress, a bill to provide a health benefits program for Government employees, as reported in the Senate on July 2, 1959.

This bill would provide generally for four basic types of health insurance plans to be made available to Federal employees and annuitants, and members of their families. The bill also covers the level and pattern of benefits to be provided under the various plans; places certain responsibilities in the Civil Service Commission for overall administration; provides for payroll deductions and matching contributions by the Government; establishes a Federal Employees'

Health Benefits Fund; and creates a Federal Employees Health Benefits Advisory Council and states its duties.

The Department of Defense fully recognizes the importance of group health insurance for its employees. For many years it has encouraged these employees to participate in available group health insurance programs on a voluntary basis, and large numbers are currently participating in such programs. This Department has also consistently supported recommendations for health insurance which have been included in the legislative programs of this administration.

The Department of Defense therefore endorses the basic purposes of S. 2162 and favors the enactment of legislation which will establish a Federal employee health benefits program that will provide sound protection against the high costs of illness at a price which both the employees and the Government can afford. The Department further believes that July 1, 1960, should be the goal for making such program fully effective and removing the unfortunate lag between the Federal Government and private industry in this important area.

Time has not permitted the full and detailed analysis of all the technical provisions of S. 2162 which would be necessary in order to determine whether changes in any of those provisions might produce improvements. However, the Department of Defense considers that this bill does provide the basis for a sound, well-rounded program of health insurance.

From the standpoint of assuring the most economical and efficient administration of this program, however, the Department of Defense is concerned with those provisions of S. 2162 which establish and prescribe the functions and duties of the Federal Employees Health Benefits Advisory Council.

The wording of section 12 makes this Council much more than an advisory body. It has monitoring and investigative functions, may receive reports and information from various individuals concerned with the program (which to some degree at least give it the character of a grievance committee), and may recommend legislation, presumably with or without concurrence of the Civil Service Commission which is the agency responsible for the program.

All these powers and duties of the Advisory Council will, in the opinion of the Department of Defense, tend to dilute and impair the position of the Civil Service Commission as the administrator of the program, create confusion, and make more complicated the administration of a program which will be complicated enough even under the best of circumstances. It is the belief of the Department of Defense that the Advisory Council should be confined to those functions which the name implies—advising and making recommendations to the Civil Service Commission.

It would also seem unnecessary and undesirable to provide for membership on the Council of representatives of university schools of medicine, hospital administration, and public health. While these are undoubtedly sources from which the Civil Service Commission would desire to seek information and advice from time to time, this can be done without providing membership and votes on a statutory advisory council. Their interest in and identification with the program established by S. 2162 is not this direct.

S. 2162 provides for an equal sharing by employees and the Government of contributions under the program, which exceeds the maximum

Government contribution previously recommended by the administration. It is estimated that costs to the Department of Defense from legislation of this nature will approximate one-half the costs to the Government, exclusive of costs attributable to coverage of annuitants. Since S. 2162 represents pending legislation, no provision has been made for these costs in the budget of the Department.

The Bureau of the Budget advises that there is no objection to the submission of this report to the Congress.

Sincerely yours,

L. NIEDERLEHNER,
Deputy General Counsel.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, July 21, 1959.

Hon. TOM MURRAY,
Chairman, Committee on Post Office and Civil Service,
House of Representatives.

DEAR MR. CHAIRMAN: In compliance with your request of July 8, 1959, we offer our comments on S. 2162, as passed by the Senate.

The bill provides generally that there shall be made available to Government employees health benefit plans of the currently popular types, the cost of which will be borne equally by the Government and the employees concerned. The program will generally give Government employees protection equivalent to that enjoyed by commercial and industrial employees.

While the bill involves a matter of policy upon which we offer no recommendation, the following observations are made for such consideration as they may warrant.

Section 2.—Many terms appearing in the bill, some of which are used interchangeably, are not clear. Among these are hospital care, hospital benefits, medical services, ambulatory patients, hospital services, hospital outpatient, other ambulatory patients, diagnostic and treatment services, and professional services. We assume that the Commission will include in its regulations such definitions as may be necessary.

Section 5 (general comments on subsections (a) and (b)).—Subsection (a) provides the benefits to be included in health plans but subsection (b) authorizes the Commission to substitute "alternative" benefits for any and all of the benefits specified in subsection (a). As the section is now written, the alternative benefits could be exclusive of major medical care. We suggest that subsection (b) be revised to insure that the alternative benefits shall include both basic and major medical protection at least equal to that provided under subsection (a). Also, in the event the Commission finds, in the administration of the program, that costs are being adversely affected by excessive or unjustified use of health services, there may be required some means of protecting the interests of the employees who refrain from such practices. Possibly, as an aid to the Commission, the authority to include deductibles and coinsurance should be made applicable to any benefits offered by the program.

Section 5(a)(1)(A).—While there is general provision for 120 days hospital care, the duration of care provided in cases of tuberculosis and nervous and mental conditions is limited to 30 days. We think

that the supplemental benefits would apply in these cases, immediately after the expiration of 30 days. However, the relationship of this section to the major medical care provided in section 5(a)(1)(E) is not entirely clear. Therefore, we suggest the insertion of an express provision in the bill designating the point at which a tuberculosis or mental patient would be covered by major medical care.

Section 5(a)(1)(B) and 5(a)(1)(C).—The language "to persons with incomes less than those of the one-quarter of Federal employees earning the highest incomes" apparently is intended to preclude graduated medical and surgical fees to Federal employees with incomes less than those in the one-quarter group of employees that earn the highest incomes. However, enactment of the language would constitute congressional recognition of the practice of graduated medical and surgical fees to personnel with incomes in the "one-quarter of Federal employees earning the highest incomes." We doubt that congressional recognition should be given to the practice of graduating medical and surgical fees upon the basis of income. Therefore, you may wish to delete the language in the section relating to graduated fees.

Section 5(a)(1)(D).—Benefits for ambulatory patients should be clarified. As the subsection now reads, it is not clear whether it was the intention to require that each of the four plans specified in section 4 include provisions for protection against medical costs for ambulatory patients, or whether care for this class of patients would be restricted to service benefit plans. Further, it is not clear whether the contemplated medical costs would apply to visits of patients to the physician's office when the patient had not been previously hospitalized for the condition subsequently treated at the office. It is likewise not clear whether the section contemplates the payment for house calls made by physicians.

Section 5(a)(1)(E).—The section provides for a sharing of the first $1,500 of expenses and that the carrier shall pay all costs in excess of $1,500 subject to maximums determined by the Commission. Your committee may wish to consider the desirability of prescribing in the law itself maximum and minimum amounts that would be payable in addition to the first $1,500. This point would be of particular significance if the cost of benefits provided under a plan should increase to a point where it may be necessary for the Commission to reduce certain of such benefits to stay within the limit of available funds.

Also, we suggest the addition of the following language to be inserted after the word "subparagraph" appearing on line 10, page 31, "shall include any and all diseases but".

Section 5(a)(1)(F).—Apparently under this paragraph no supplemental benefits would be provided for any normal delivery even though complications may develop prior to the patients' complete recovery.

Section 5(a)(2).—We do not have the details of the benefits which may be offered under the indemnity plan. We recommend, however, that the bill require or, at least, that the committee report specify that the value of benefits under the indemnity plan generally coincide with the value of the services furnished under the service plan, including coverage of all diseases.

Section 6.—The bill specifies that the Commission shall approve two nationwide plans, one of the service type and one of the indemnity type, and authorizes the Commission to enter into nationwide con-

tracts for benefits provided by the two plans. Under such conditions the question arises as to what recognition is to be given to the variations in hospital room rates, medical services, and surgical fees between various localities. Since schedules of benefits will be applicable nationwide, there will be a tendency for those hospitals and surgeons heretofore charging less than the stated maximum to increase their rates and fees until they reach the maximum levels specified. This result would add to the cost of the program for both the employee and the Government. In our opinion the bill should specify that the nationwide contracts contain language assigning to the carrier responsibility for maintaining costs at prevailing local levels. We suggest language similar to the following be added to section 6(b) "Any nationwide prime contract shall include a requirement that the carrier's subcontracts or other arrangements with corporations, associations, groups, doctors, hospitals, and other providers of health services shall be stated at cost levels no higher than the (1) charges to the general public, or (2) schedules of health benefit costs in local health benefit plans."

We suggest that this section be amended to authorize the Commission to require reinsurance if it deems such action is necessary to protect the interests of the Government. Similar reinsurance is required under the Government Employees Life Insurance Act.

Section 7(b).—This section covers employees who are on leave without pay and would vest in the Commission discretion to regulate the coverage to be granted. Presumably, this discretion is necessary to enable consideration of the circumstances involved in individual cases concerning authorized or unauthorized leave without pay. Consideration might be given to providing the Commission guidelines for its administration of this section in your committee's report.

Section 8.—We recommend a technical revision in this section After the word "Fund" on page 36, line 14, insert the language "which shall be administered by the Commission and". Also, on page 37, after the word "Fund" appearing on line 15, insert the language "when directed by the Commission."

Sincerely yours,

JOSEPH CAMPBELL,
Comptroller General of the United States.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, August 17, 1959.

B–119033.

Hon. TOM MURRAY,
Chairman, Committee on Post Office and Civil Service,
House of Representatives.

DEAR MR. CHAIRMAN: As a result of a number of conferences between members of our respective staffs we have been requested to report on the version of the bill S. 2162 presently under consideration by your committee. We are pleased to offer the following comments on the bill as presently revised by the committee.

Health benefit plans (sec. 4, p. 30)

Section 4 of the bill provides that there shall be one Government-wide service benefit plan and one Government-wide indemnity plan.

Testimony before the committee has disclosed clearly that in order to provide a health plan within the reach of the employees in the lower grades, and for basic fiscal policy reasons, a benefits plan with relatively low or "thin" benefits will be acquired. Under the requirement that only one service and one indemnity plan may be operative, such plans may and probably will not provide a benefit level desired by the majority of employees in the middle or upper grades, nor will the new uniform medium or low benefit plan compare favorably with broader coverage now carried by many employees. We suggest that the committee consider revising this section of the bill to require the providing of at least two levels of benefits for each of the two primary plans created by sections 4(1) and 4(2). Two levels of benefits would provide a more flexible choice to the employees, enabling them to consider local cost conditions, and would also recognize the employees' ability to pay. In our opinion the option for two levels of benefits under each major plan could be included within a single contract with the respective carriers. While the cost of administration will necessarily be increased by additional options, we believe that the matter can be worked out by the Commission to assure a minimum of increased costs. The following language, or some modification thereof, added to sections 4(1) and 4(2) would provide a basis for the Commission to develop two levels of benefits and two levels of cost under each of the two nationwide plans:

"*Provided*, That any such plan shall include two levels of benefits and two related levels of subscription or premium charges."

Contracting authority (sec. 6, p. 33)

The committee has received testimony that experience under many health plans indicates they are subject to costly abuses. Published material indicates a rather significant overutilization of hospital services when the individuals are insured for hospital services only. Some published data has indicated that unnecessary hospitalization under insurance or service plans runs as high as 20 percent.

If abuses occur, then costs borne by the employee and the Government will be correspondingly higher. Conversely, if the unnecessary services and the related costs are curtailed, then more funds will be available to provide the necessary benefits. The unnecessary use of hospital room and board in order to obtain other needed services not available unless the patient is hospitalized, is an example of abuse. The insurance industry and the large employers have devised contract provisions designed to curtail nonessential utilization of health services, and it would seem that where appropriate the Government should apply similar and other effective provisions. Coverage of all medical services, coupled with coinsurance and deductibles are among the corrective devices used. The committee may wish to state in the bill an expression of policy for the guidance of the Commission in framing contracts to provide to the extent possible for the curtailment of abuses of the Government health plans by the users of the services or benefits. This could be accomplished by adding a provision to section 6 of the bill, reading substantially as follows:

"Regulations of the Commission shall require that all plans or contracts include benefits, in specified categories of health services, and at such levels, as the Commission determines necessary to restrict excessive utilization or abuse of any service. The standards shall

include such other provisions, including coinsurance and deductible provisions, determined by the Commission to be necessary to prevent abuses of the program."

Contributions (sec. 7(a)(1), p. 36)

We wish to point out that section 7(a)(1) as written, permits the Commission full discretion regarding the level of benefits that may be acquired. The benefits may be set very low—substantially below the amounts stated in subparagraphs (i) and (ii)—and in such cases the Government would pay 50 percent of the costs. If the benefits acquired are liberal and the costs higher, then the Government may pay less than 50 percent of the costs.

Also, we note that the minimums and maximums between which the Commission must set the "prescribed" amounts are apparently intended to be applicable uniformly to all plans. However, it is possible to interpret the language of this section as authorizing variable "prescribed" amounts, within the three categories of minimum and maximum limits stated in the bill. We believe this would be inequitable to employees who were members of the plans assigned low "prescribed" amounts. We suggest the following change on line 7, page 36:

"The amounts so prescribed, which shall be uniform for all plans, shall not—."

Subscription charges and premiums

The bill contains numerous references to "subscription charges" and "premiums." However, the manner in which the terms are used indicates that in some instances these terms refer to the combined amount represented by payroll deductions from employees and the Government's transfer to the fund, and in other instances one or both of the terms refer to the payment from the fund to the carriers. These amounts paid into the fund will not necessarily be the same as the amounts paid out to carriers, as the bill is now written. The difference in the amounts is due to allowances for expenses and credits to the reserve. It is suggested that the use of these terms throughout the bill be reviewed and their specific use clarified by editorial change.

We will be pleased to provide any further information or assistance in connection with this proposed legislation that the committee desires.

Sincerely yours,

FRANK H. WEITZEL,
Assistant Comptroller General of the United States.

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